Alberta Health Services

2016-17

Alberta Health Services

Health Plan & Business Plan

ALBERTA HEALTH SERVICES' 2016-2017 HEALTH PLAN & BUSINESS PLAN

Statement of Accountability

The one-year Health Plan and Business Plan for the period commencing April 1, 2016, was prepared under the Board's direction in accordance with the *Regional Health Authorities Act* and direction provided by the Minister of Health.

The strategic goals and objectives of Alberta Health Services (AHS) have been developed in the context of legislated responsibilities, Alberta Health's Business Plan, and provincial government expectations as communicated by the Minister.

Performance measures are included in the Health Plan as the basis for assessing achievements.

This plan is largely a continuation of AHS' previous health plan and reflects completion of important work that began in 2014 as well as new commitment to enhance capacity for mental health, continuing care, home care, cancer care, primary care and Aboriginal health. To support this year's plan, AHS will develop a one-year action plan, which outlines the key initiatives and actions to achieve the goals and objectives outlined in the Health Plan. This includes actions that support health care across the province, those that are supported by innovation and which will significantly impact how services are delivered.

In future, AHS will be moving to a three-year planning cycle which means that, every three years, we will engage the organization in an extensive planning process. This planning process will include the development of robust performance measures and targets that will allow us to align and measure our success in achieving our goals and objectives under the direction of the Board. Work is beginning on the new Health Plan for 2017 – 2020.

The AHS Board and administration of AHS are committed to achieving the planned results laid out in this one-year health plan.

Respectfully submitted on behalf of Alberta Health Services,

[Original Signed by]

Linda Hughes
Chair, Alberta Health Services Board

Under Section 5 of the *Regional Health Authorities Act*, Alberta Health Services is required to:

i. promote and protect the health of the population in the health region and work toward the prevention of disease and injury,

ii. assess on an ongoing basis the health needs of the health region,

iii. determine priorities in the provision of health services in the health region and allocate resources accordingly,

iv. ensure that reasonable access to quality health services is provided in and through the health region, and

v. promote the provision of health services in a manner that is responsive to the needs of individuals and communities and supports the integration of services and facilities in the health region.

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MESSAGE FROM ALBERTA HEALTH SERVICES' PRESIDENT AND CHIEF EXECUTIVE OFFICER

Health care is a people business.

The staff, physicians and volunteers of Alberta Health Services (AHS) care for patients, clients and families – and they also care for each other, and they care about their work.

Our people are truly AHS' greatest asset.

To harness their energy and talents, AHS needs to provide clarity about who we are, what we hold dear, where we are going and how we will get there.

The 2016-2017 Health Plan and Business Plan is an important part of that equation.

We're taking steps to fill in other missing parts.

In February 2016, AHS completed a year-long project to land on a vision statement for the organization that our workforce could rally behind; a vision that belongs to all Albertans.

That statement is: **Healthy Albertans. Healthy Communities. Together.**

I like how the vision statement reflects inclusivity, community and our shared responsibility for health and wellness. It points AHS in the direction we need to go.

We're also looking to engage our workforce and key external stakeholders in order to refresh our core values. This is also crucial. Values are at the heart of what we stand for and clearly establish what we will not compromise on at any cost, under any circumstances.

Once this work is done, AHS will have a vision, a mission, a set of core values, four foundational strategies (Patient First Strategy; Our People Strategy; Clinical Research, Innovation and Analytics Strategy; and IM/IT Strategy) that will support the strategic goals and objectives outlined in the 2016-2017 Health Plan and Business Plan.

We are living in tough economic times here in Alberta. Yet I remain optimistic.

Having a provincial health care system gives us a landscape – unique in Canada – to collaborate, to share best practices and to drive innovation that improves quality and value for all patients, clients and families, no matter where they live.

We will continue to build a healthier Alberta.

Together.

[Original Signed by]

Dr. Verna Yiu,
President and Chief Executive Officer
Alberta Health Services

WHO WE ARE

- We are skilled and dedicated health professionals, support staff, volunteers and physicians who promote wellness, prevent disease and injury, and provide health care every day to a diverse population of about four million Albertans, as well as to some residents of Saskatchewan, B.C. and the Northwest Territories.
- Alberta Health Services (AHS) is Canada's first and largest provincewide, fully integrated health system. The creation of AHS supports consistent access to health services and standards, and better co-ordination of services across the province and within each of AHS' five zones.
- AHS has more than 108,000 employees, including approximately 99,900 direct AHS employees (excluding Covenant Health staff) and almost 8,200 staff working in AHS wholly-owned subsidiaries, such as Carewest, CapitalCare Group and Calgary Laboratory Services. We are also supported by nearly 15,600 volunteers and almost 9,300 physicians.
- Students from universities and colleges – within and outside of Alberta – receive clinical education in AHS facilities and community locations.
- Programs and services are offered at more than 650 facilities throughout the province, including hospitals, clinics, continuing care facilities, cancer centres, mental health facilities and community health sites. We have 106 acute care hospitals, five stand-alone psychiatric facilities plus partnership in 42 primary care networks.
- As of March 31, 2015, AHS has 8,471 acute care beds; 23,742 continuing care beds/ spaces (long-term care and supportive living); 208 community palliative and hospice beds; and 2,439 addiction and mental health beds.
- The province also has an extensive network of community-based services designed to assist Albertans to maintain or improve their health status.

Did You Know?

- We are one of the largest employers in Canada.
- There were more than 2.1 million visits to Alberta's emergency departments and more than 195,000 visits to the province's urgent care centres in 2014-15.
- More than 7,800 people were placed into continuing care living options and almost 115,000 people received home care services in 2014-15.
- In 2014-15, Health Link had more than one million client/patient contacts, there were more than 2.4 million visits to MyHealth.Alberta.ca, and more than 1.2 million seasonal influenza immunizations were administered.
- We work with 12 Health Advisory Councils and three Provincial Advisory Councils (Wisdom, Cancer and Addiction & Mental Health). They provide advice and feedback, helping to bring the voice of Albertans to decision-making at a local and provincial level.
- AHS works with the Wisdom Council to support a collective understanding and better response to the needs of First Nations, Métis and Inuit people.
- We have 13 Strategic Clinical Networks driving innovation, finding value and improving patient outcomes, experiences and satisfaction.

CHALLENGES AND OPPORTUNITIES

AHS has made significant progress toward its strategic goals and objectives. However, many of the challenges facing the health care system in Canada are also affecting Alberta.

Alberta's population is growing

Alberta is the fastest-growing province in Canada and currently has a population of slightly more than four million people. In 2015, Alberta's population growth rate doubled the national average (1.8 per cent and 0.9 per cent, respectively).

Alberta's population is living longer

Albertans born in 2015 are expected to live to 81.9 years of age; that's up from 79.6 years expected for Albertans born in 2000. As we age, we depend more on the health care system. By 2031, one in five Albertans is expected to be 65 or older.

Alberta has diverse community needs

Along with a growing population, Alberta has an increasingly diverse population, with large rural and some remote populations. Certain geographical areas within our province are composed of different ethnicities, different population structures and unique health needs requiring tailored approaches to health care delivery. We must better understand and respond to the health needs of our diverse populations. Patient, family and community engagement is critical to gaining the understanding that will improve the health system and result in better health for all Albertans.

Alberta is facing increased demand and costs for health services

While we work to improve the services we provide and the health outcomes for Albertans, we must also address the cost and sustainability of services. We are facing service and cost pressures as a result of increased activity and growth in the province, and we must continue to be responsible managers of our financial, capital and human resources.

Budget, aging workforce and existing health infrastructure challenges continue as we are asked to do more with limited resources and financial constraints. We must make difficult decisions in the coming years to encourage cost containment and be a sustainable health care system. Our focus still needs to be on quality and patient care, while doing so in a more efficient and cost-effective way.

Did You Know?

- At 36 years of age, Alberta has the lowest median age of all provinces; this is expected to contribute to even more population growth. More people in the province means more demand on our health care resources.
- Between 2009 and 2014, the percentage of the Alberta population with two or more of the following chronic conditions (asthma, diabetes, chronic obstructive pulmonary disease, heart disease, heart failure or hypertension) increased from 8.8 to 10.2 per cent. In 2014, there were slightly more than 419,000 Albertans with at least two of these conditions. Each year, about 28,500 new people develop two or more of these conditions.
- Many Albertans with complex needs are often treated through hospital settings when their care could be managed better in the community.
- Strategic Clinical Networks of health care teams are finding better ways to deliver health care by sharing research, experiences and wisdom across the province.

OUR DIRECTION

Vision

Healthy Albertans. Healthy Communities. Together. This is the vision for AHS. It's what we are striving to be and what we consider in every decision we make. After talking to our external partners, employees, physicians and volunteers extensively, AHS launched this new vision statement in March 2016.

The need for a new vision came out of the 2014 Workforce Engagement Survey, in which our workforce told us they need a clear picture of AHS' desired future and how their roles contribute to our shared successes. AHS heard similar themes in the consultations for Our People Strategy during the spring and summer of 2015.

The AHS vision statement inspires us and unites us as an organization as we work to provide high-quality health care to Albertans.

AHS' vision can't stand alone; it must align with our mission and values, our Health Plan and Business Plan, and our four foundational strategies.

A mission statement communicates our purpose and defines who we will serve and how.

Mission

The mission of Alberta Health Services is ***to provide a patient-focused, quality health system that is accessible and sustainable for all Albertans.***

If our vision is our inspiration behind the work we do, and the mission gives us our reason for being, our values define what we believe in and what we stand for, as we go about the work we do each day. AHS currently has a set of seven core values. These values were established soon after AHS was formed and they have served to guide our decisions, influence our strategic directions, and anchor actions in a common understanding of what is important to us.

Values

Core values inspire, empower and guide how we work together with patients, clients, families and each other. In March 2016, we took steps to examine our values. We talked to our partners and teams inside and outside AHS to ensure these values reflect the current organization and active involvement from the AHS workforce and our partners.

That consultation led us to the five values represented by AHS CARES: Compassion, Accountability, Respect, Excellence and Safety. These values provide the blueprint across our organization for decision-making and set the criteria for our performance.

AHS cares

compassion

We show kindness and empathy for all in our care, and for each other.

accountability

We are honest, principled and transparent.

respect

We treat others with respect and dignity.

excellence

We strive to be our best and give our best.

safety

We place safety and quality improvement at the centre of all our decisions.

Goals

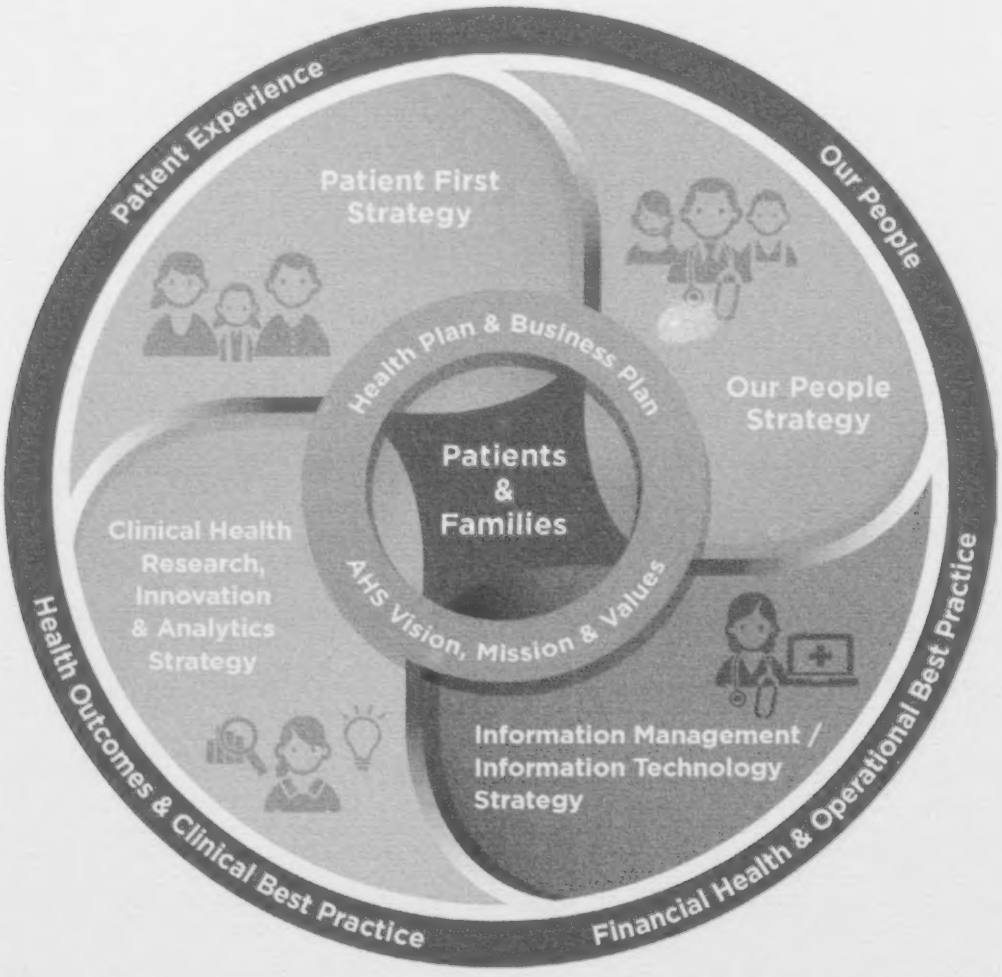
Everything AHS employees, physicians and volunteers do should advance patient- and family-centred care. And we know that excellent patient- and family-centred care is attainable when employees, physicians and volunteers feel safe, healthy and valued in the work environment.

Using the AHS Health Plan and Business Plan as our roadmap, AHS has worked with employees, physicians, volunteers and partners to build four foundational strategies to achieve the following ***goals***:

- Build a culture of patient-, family- and community-centred care to improve patient experience.
- Improve health outcomes through clinical best practices.
- Ensure our people feel safe, healthy and valued.
- Achieve financial sustainability through operational best practices.

The four foundational strategies described on the following page will guide efforts to sustain safe, high-quality health care delivery for the benefit of all Albertans.

They are built on the basis of our values and mission, and provide a solid framework for us to manage the demands within our system and to coordinate efforts across the province.


Patient Experience
Our People
Health Outcomes & Clinical Best Practice
Financial Health & Operational Best Practice
Patient First Strategy
Our People Strategy
Clinical Health Research, Innovation & Analytics Strategy
Information Management / Information Technology Strategy
Health Plan & Business Plan
Patients & Families
AHS Vision, Mission & Values

Foundational Strategies

Aligned with our goals, our foundational strategies were developed following extensive consultations with key stakeholders — including patients, clients and their families. These strategies address pressures on the health system and protect the sustainability of safe, high-quality health care delivery.

Patient First Strategy

What we will do: Strengthen AHS' culture and practices to ensure patients and families are at the centre of all health care activities, decisions and teams.

How we will do it: Promote respectful patient/provider interactions; enhance communication between providers and patients/ clients/families; support a team-based approach to care; and improve transitions in care. Involve patients and families on key strategic committees, including Strategic Clinical Networks, zone leadership teams, and any other place where their voice can guide our thinking.

Our People Strategy

What we will do: Promote how we support each other. It is about creating a culture in which we all feel safe, healthy, and valued, and can reach our full potential. Through Our People Strategy, workforce engagement will be higher, and patient and family experiences will improve as a result.

How we will do it: Promote our vision for the organization with our shared purpose and common goals; build a safe, healthy and inclusive place to work; develop excellent leadership that will respect, value and support the workforce; create a culture of empowerment by giving people access to the resources and development opportunities they need to do their jobs effectively.

Clinical Health Research, Innovation and Analytics Strategy

What we will do: Generate, share and use evidence in the delivery of care to improve patient outcomes and to solve the complex challenges affecting the health system.

How we will do it: Use Strategic Clinical Networks and clinical best practices to engage partners in research and innovation; identify gaps where research and innovation will have a significant benefit to patients and the health system; provide easy, timely and secure access to health information; apply and spread knowledge; and innovate to achieve service excellence.

Information Management / Information Technology (IM/IT) Strategy

What we will do: Allow health information to flow with the patient, so that providers and patients across the province can have access to complete information at the point of care and learn from the data in the future.

How we will do it: Use information and technology to transform care in three key ways: enable Albertans to have electronic access to their own health records to empower them to be an integral part of their care team; enable information flow across the continuum, including creating best practice standards to be embedded in the technology at point of care; and learn from the care we deliver to continue to improve quality and outcomes through the use of information and analytics.

Goal 1: Build a Culture of Patient-Centred Care to Improve Experience

Patients, their families and communities are the centre of everything we do and every decision we make. Albertans have told us they want health care that is focused on their individual health needs, supports them in staying healthy, and helps them to get better when they need it most.

AHS is fully committed to the needs of Albertans and has developed a Patient First Strategy to help build a culture that organizes care around the patient and their families.

This strategy will enable us to advance health care in Alberta by empowering and enabling Albertans to be at the centre of their health care team, improving their own health and wellness.

Albertans want to know they can access high-quality health services when they need them. To maintain these supports and services, we need to ensure our health care system is accessible and appropriate. This is achieved through collaborating at the provincial and local levels, gathering input from communities and increasing local decision-making authority. A focus on quality, including patient experience and safety, ensures systems, capacity and tools are used to build the organization's culture and shape its evolution to continuously improve our performance and outcomes while also looking for streamlined workflow and cost efficiencies. Quality improvement processes lead to improved clinical practice and performance, a more coordinated and seamless approach to care, and more satisfied patients and staff.

1. Improve the Patient Experience

Patient- and family-centred care and patient satisfaction are crucial to better quality and better outcomes. The Patient First Strategy aims to strengthen AHS' culture and practices to ensure patients and families are at the centre of all health care activities, decisions and teams. This includes enhancing communications, promoting respect, supporting a team-based approach to care and improving transitions in care.

There are many examples of these activities happening every day in AHS. This strategy ensures a more consistent and systematic approach to optimizing the abilities of our leadership, physicians, and staff in providing patient- and family-centred care.

Our People Strategy supports the Patient First Strategy by addressing the experience of providing care. Research points to a strong relationship between engaged people and organizational success. Within health care, evidence shows that patient ratings go up and adverse patient events go down when people are more engaged. Through Our People Strategy, workforce engagement will be higher, and patient and family experiences will improve as a result.

The Patient First Strategy will enter the implementation phase in 2016 across the organization. A major success component will be to support zone operations by embedding the strategy and patient- and family-centred care elements at zone, site, program and local levels.

2. Provide Better Transitions in Care

AHS continues to work toward seamless and well-coordinated transitions of care between different providers, locations, or levels of care. There are many examples where care transitions can go well or go poorly: from the family doctor to the specialist, between units or areas of care within a site or between sites. This is a significant focus of the Patient First Strategy and will be coordinated through CoACT and other initiatives, such as the Alberta Initiative for Integration and Innovation and TeamCARE.

This work will include the development of plans of care and standardized transition processes that better support patients moving between services or providers (e.g. to primary health care) or back to home.

Strong primary health care is critical for a high-performing, patient- and family-centred health care system. Communities must have effective services and supports that help people to address their addiction and mental health needs. By partnering with primary health care providers and collaborating with community and social services, AHS will work to increase addiction and mental health capacity in primary care and support Albertans' ability to receive the help they need in their community. AHS will also establish coordinated navigation support to improve access to addiction and mental health services.

AHS will work with its partners to expand capacity for children's mental health services, strengthen community capacity, support mental health teams, and provide supports for complex patients with mental health and developmental disabilities.

AHS will also work with many stakeholders, including the federal government and First Nations, Inuit and Métis communities, to address access and culturally appropriate care for underserved populations and to deliver services focusing on the primary health care needs of this population using a collaborative interdisciplinary team approach.

Access to basic cancer services in Alberta is also a major and growing concern. AHS will expand clinic capacity and increase capacity for cancer treatments, therapies and transplant services, particularly within rural areas, to enhance access to services closer to home and ultimately reduce wait times.

To also help improve transitions, Strategic Clinical Networks (SCNs) are spearheading the development and implementation of clinical care pathways. These pathways provide a roadmap for providers and patients on what to expect in their care across the entire continuum. Specifically, AHS is moving towards using consistent leading practices to treat chronic conditions and developing care pathways for chronic obstructive pulmonary disease, breast cancer and congestive heart failure. This ensures effective transitions of care through different parts of the health system or through the development of appropriate integrated care teams. The development of these pathways will continue through our SCNs.

3. Enhance Community-Based Options

AHS will focus on keeping Albertans in their homes. Many of today's seniors are more independent and healthier than in previous generations; others still require health care with options that allow them to continue living in their own homes and communities. Also, more community-based options are needed for children and adults with special needs.

AHS will continue implementing the Continuing Care Capacity Plan, which focuses on strengthening home care; offering more continuing care living options, including designated supportive living beds/spaces that combine housing with supports for daily living and health care; and providing caregiver and respite support to enable people to stay in their homes. In addition, we will add continuing care beds/spaces—including restorative care (which focuses on restoring a person's abilities to a level that makes independent living an option) and palliative care —to help reduce demand for hospital beds, ease congestion in emergency departments, and add capacity to the overall health care system.

Expanding home care services will enable patients to remain in their homes and decrease utilization of acute care and emergency department resources. This also addresses providing appropriate care in the appropriate setting.

CoACT
Teams in Action

CoACT is implementing a model of care where care providers collaborate more closely with each other, patients and their families.

We all want to deliver care that is patient-centred, compassionate and seamless. We want patients to receive the right care, at the right place, at the right time, by the right members of their care team. CoACT designs tools and processes to make this happen.

TeamCARE
Creating & Achieving Reliable Excellence

TeamCARE is a team-based training program that seeks to improve the reliability of care and enhance patient safety through empowering staff with teamwork and communication skills and techniques.

4. Improve System Flow

Local and provincial initiatives use interdisciplinary teams, care plans and other innovations to address patient flow, emergency department throughput (e.g., rapid transfer units) and capacity. They also improve access and care for our patients and shift care to the community. By moving patients from the emergency department and directing them to the most appropriate service, the patient is cared for in the right location with the right service providers; thereby enhancing their quality of care.

We will learn from what is already working well in the organization and share best practices across the province. This includes the work of CoACT and TeamCARE, which are committed to putting people first, enabling high-performing teams, and using quality processes and measures to ensure patient-centred, collaborative care and smooth transitions between levels of care, especially those with complex high needs.

Finally, we will have a strong focus on operational best practices, identifying where we vary from other jurisdictions.

Strategic Clinical Networks (SCNs) are actively bringing new models of care, along with evidence-based care pathways to improve clinical care by removing barriers that lead to variation in practice. In doing so, improvements lead to better utilization of our services.

Strong primary health care and population health initiatives are critical for a high performing, patient- and family-centred health care system. Communities should have access to effective services and environments that support Albertans to maintain wellness, prevent illness, manage chronic disease, recover from illness or injury, and address the needs of the frail and their caregivers. In this way, people will stay healthy, emergency department visits and hospitalizations are reduced, and those who do receive hospital-based services experience shorter lengths of stay and are less likely to require readmission. Currently, Primary Care Network teams work with Population Public Health and Aboriginal teams to provide Albertans with access to health promotion, prevention of illness and early intervention. Primary health care teams also help to coordinate a patient's journey through the health system.

Goal 2: Health Outcomes and Clinical Best Practice

AHS encourages Albertans to be partners in health to achieve better health outcomes for themselves, their families and their communities. AHS partners with patients/clients and families, staff and physicians, volunteers, local communities, external health care providers, professional and accrediting bodies, research and academic organizations, governments and others.

Together, we are building a health system that gives patients control over factors that affect their health, improves service quality, promotes leading practices, consistently applies standards, and increases local decision-making. Even given the current climate of fiscal constraint, we will also be focusing on continuous quality improvement, particularly on our core services, patient and staff safety, patient satisfaction, and operational best practices to identify opportunities to streamline and improve service delivery and better outcomes.

5. Ensure a Quality and Safety Focus in Patient Care

Ongoing attention to patient and staff safety is important to providing quality services, supporting positive outcomes for patients, and ensuring a safe, healthy and productive workforce. AHS will continue to focus on accreditation standards that address patient safety areas, such as improved medication management, falls prevention, standardized equipment cleaning programs and other infection control practices.

SCNs are working on several areas of care (e.g. emergency) and with specific populations (e.g. seniors) to ensure appropriate clinical practice and to find new and innovative ways to achieve effective, efficient, safe, accessible and acceptable care to Albertans. Each SCN addresses health across the continuum of care from population health to end of life care.

AHS will also continue to implement and spread AHS Improvement Way (AIW) initiatives that offer innovative, locally developed approaches to improve efficiency, effectiveness, engagement, and safety in daily work.

In addition, AHS will be implementing business continuity and disaster recovery plans for all AHS service areas to ensure effective readiness by preparing for, responding to, resuming, controlling and recovering from a range of significant incidents.

6. Improve Surgical Capacity Management

Surgical capacity management refers to a range of actions aimed at aligning our surgical services with the needs of Albertans. Initiatives will focus on quality improvement, managing demand for services and improving outcomes.

AHS continues to work closely with the Surgery Strategic Clinical Network to implement initiatives that improve outcomes for patients after surgery, such as:

- Adult Code Access Targets for Surgery (aCATS) aims at helping surgeons deliver exceptional surgical care in a safe and timely manner.
- Enhanced Recovery After Surgery (ERAS) standardizes care before, during and after surgery, in an effort to get patients back on their feet sooner while shortening hospital stays and reducing complications after surgery.
- National Surgery Quality Improvement Program (NSQIP) uses clinical data to understand and improve performance.

7. Improve Coordination of Emergency Medical Services in Rural and Remote Communities

Emergency Medical Services (EMS) is engaging with communities to better understand their needs. The implementation of an EMS Service Plan – including the development of local community service plans – will ensure the coordination of quality, appropriate patient services.

EMS provides emergency response and inter-facility transfers by ground ambulance, non- ambulance transfer vehicles, and rotary and fixed wing air ambulance. As Alberta paramedics move under the *Health Professions Act*, AHS will also work with the government to expand the role of paramedics which includes providing more front-line care, collaborating with other health care providers and delivering innovative health service delivery. AHS is focused on improving EMS access and response for the one-in-four Albertans who live in rural and remote communities.

8. Integrate Research, Innovation and Analytics in the Delivery of Care

By integrating research and innovation into the delivery of care, AHS nurtures health research breakthroughs, innovations and new knowledge to where they generate real-world clinical value. AHS created the Strategy for Clinical Health Research, Innovation and Analytics, 2015-2020, as a blueprint to fully integrate those activities in the health care system.

- Clinical health research can focus on improving the diagnosis and treatment of disease and injury, improving the health and quality of life of individuals, improving the effectiveness of health professionals, or on improving the health of the population.
- Innovation means improving ways of doing things. It can mean better quality and safety of care, better patient outcomes or experience, or greater productivity, efficiency or savings. Innovation can improve a device, a drug, a technique, a method, a system or a service.
- Analytics is the transformation of data, facts or figures into useful information to guide decision-making, improve performance and deliver quality care.

The Strategic Clinical Networks (SCNs) are the engines of quality and innovation designed to bring teams of front-line health care providers, physicians, managers, patients, scholars and community partners together to find, and then spread, the best care options for patients based on clinical evidence.

9. Promote and Support Wellness for Our Communities

By focusing on health promotion, wellness, and disease and injury prevention, AHS Population, Public and Aboriginal Health teams (PPAH) are enabling Albertans to take better care of themselves, make appropriate health care decisions for themselves and be more involved in and informed about their own care. This will decrease the future demand for care and treatment, improve the quality of life of Albertans and contribute to the sustainability of our health system.

Working collaboratively with Alberta Health and other health and non-health agencies, we will develop and implement an integrated chronic and communicable disease screening and prevention approach. AHS will continue to focus on public health issues such as reducing communicable disease through implementation of preventive measures (e.g. immunizations), reducing risk factors for chronic disease and cancer through direct intervention (e.g. Alberta Screening and Prevention Initiative through Primary Care Networks, Family Care Clinics and PPAH) and promoting healthy social and physical environments aimed at improving the health and well-being of Albertans within and between communities.

Strategic Clinical Networks (SCNs) are driving innovation and improvements within focused areas of health care.

To get the most out of our health care system, AHS has developed networks of people who are passionate and knowledgeable about specific areas of health, challenging them to find new and innovative ways of delivering care that will provide better quality, better outcomes and better value for every Albertan.

There are 13 current SCNs:

- Addiction and Mental Health
- Bone and Joint Health
- Cancer
- Cardiovascular Health and Stroke
- Critical Care
- Diabetes, Obesity and Nutrition
- Emergency
- Kidney Health
- Maternal Newborn Child & Youth
- Population, Public and Aboriginal Health
- Respiratory Health
- Seniors Health
- Surgery

AHS will be launching two new SCNs:

- Digestive Health
- Primary Health Care

Goal 3: Our People

AHS is committed to supporting our people as we work together to deliver patient- and family-centred care. We recognize that everyone – staff, physicians and volunteers at AHS – regardless of their role, is critical in achieving this goal. This commitment is reflected in Our People Strategy, which guides how we put our people first, so they can put patients and families first in turn. The strategy will also address feedback from the Workforce Engagement Survey. Some areas of focus include:

- Empowering front-line leaders to spend more time with their teams and less time doing administrative work.
- Better communication so everyone feels connected to both AHS as a whole, and to their own site and zone.
- Designing and implementing our initiatives to better respect local contexts.
- Adapting policies, procedures and processes to bring the Patient First Strategy into our day-to-day operations.
- Providing consistent access to professional development across the province, even during times of fiscal constraint.
- Helping senior leaders feel connected to our vision and long-term direction.

This strategy outlines how we build a safe, healthy and inclusive place to work thereby improving patient and family experiences, quality and safety.

10. Engage Staff, Physicians and Volunteers in a Culture of Patient- and Family-Centred Care

All AHS staff, physicians and volunteers are crucial to the delivery of patient- and family-centred care. AHS needs strong leaders, engaged staff, and efficient and sustainable human resource services in order to achieve our priorities and long-term strategies. Using the Our People Strategy as a key foundation, AHS will focus on creating an adaptable and resilient workforce, building leadership capabilities, addressing rural workforce shortages, and effectively engaging staff, physicians and volunteers so that they can continue to provide quality and safe care to Albertans.

Ensuring a safe workplace happens through education, policies and procedures, and continuous improvement, such as managing workplace health and safety incidents and occupational injuries. AHS will continue to ensure compliance of communicable disease assessments for all of its health care workers, thereby effectively managing workplace communicable disease exposures and outbreaks. Healthy safe workers contribute to improving quality of care and patient safety.

Goal 4: Financial Health and Operational Best Practice

Becoming more efficient and integrated across Alberta is critical to sustaining Alberta's health services into the future. We will continue to address challenges through fiscal management, development of our workforce, implementation of leading practices, process improvement and preparing for the future health needs of Albertans.

AHS' first priority – always – is to ensure we provide the very best treatment and care to Albertans. But that is not enough. We must also ensure that we run the best health care system possible within our means, as efficiently and effectively as we can.

Financial sustainability is not about reducing services, quality or outcomes. It also is not about making people work harder or reducing the quality of our work life. It is about asking how we compare with our peers and whether there are opportunities to operate more efficiently. The operational best practices will guide future planning and will determine what we need to do to improve our qualitative and quantitative information to further build on this type of work.

The 2016-2017 Budget that presents the organization's financial outlook can be found in the Business Plan.

11. Ensure Investment in New Technology and/or Information Management Systems Supports Care Delivery

We want to make the right data available to the right people at the right time across the health system so that providers can rely on the data and use it in meaningful ways to improve the delivery of health care for Albertans. The rising costs of health care and continued resource constraints demand that we find new ways to improve our system and ensure its sustainability.

Technology and information systems provide individuals, health care providers, researchers and communities with the data, tools, interoperable systems and services that continue to promote an innovative, learning health system. This contributes to lower health care costs, improved population health and quality of care, and empowered Albertans. Specifically, the long-range Information Management and Information Technology (IM/IT) Strategy emphasizes the use of information for front-line automated clinical decision support and provincial electronic health records.

The benefits of a comprehensive health care record, accessible anywhere in Alberta, cannot be overstated. An electronic health record connects clinicians and patients across the continuum of care and the broader health system, including primary care, specialists, and lab and diagnostic imaging services.

We will continue to develop and enhance clinical information systems in ambulatory and acute care settings across the province to leverage the value proposition of a provincially integrated health system. This will provide better patient outcomes and improved access to clinical data for analysis and research.

12. Optimize Service Delivery through Needs-Based Service Planning and Operational Best Practices

AHS is creating comprehensive, long-range health service delivery models to achieve optimal health outcomes for Albertans. An integrated plan that addresses health service delivery and informs directions for health infrastructure is essential when planning for the long-term sustainability of the health care system.

Needs-based planning utilizes population health needs assessments and is built upon provincial service guidelines and leading practices. The process balances community aspirations, resource considerations (workforce, technological and capital) and the context of the provincial environment. Planning will include community consultation.

MEASURING AND MONITORING OUR PROGRESS

The 17 performance measures reported below were established in collaboration with Alberta Health. The measures reflect a balance across the spectrum of health care and reflect health system performance. They were developed to enable us to compare AHS performance with national or regional operational best practices. The measures play a key role in advising staff and physicians about our progress and where we may need to adjust actions to achieve the identified targets, as well as communicating with Albertans about the value provided by health funding expenditures.

Targets for 2016-17 were not established in the previous Health Plan and Business Plan. We have worked with the provincial programs, zones and sites to develop targets for the coming year. These performance targets will help us measure our progress and improve the health system. In the previous plans, some of the 2015-16 targets were more aggressive when established back in 2013.

Several of the new targets for 2016-17 are more conservative for two reasons: targets were adapted to reflect Alberta's current economic landscape; as well as to address the changes made by the Canadian Institute for Health Information (CIHI) to the definitions and methodology on how measures are calculated nationally.

Specifically, targets for measures related to Emergency Department access and continuing care placement were adjusted to reflect expected demand increases due to population growth and aging and the capacity we are able to add during a time of economic constraint. We will continue to increase continuing care spaces, expand home care and improve efficiencies in our Emergency Departments. By expanding our capacity and improving efficiencies, we will improve emergency department and hospital flow and decrease the number of patients waiting for continuing care placement. This will, however happen at a slower rate than we anticipated in 2013.

Also, targets for Acute (Actual) Length of Hospital Stay Compared to Expected Stay (ALOS/ELOS), Hospital Mortality and Mental Health Readmissions were revised due to CIHI adjustments on how patients are categorized based on diagnosis and complexity.

This adjustment impacted national results, therefore the AHS 2016-17 targets had to be revised. The historical values for these measures are updated to reflect the CIHI adjustments. Performance measures will be undergoing revisions in 2017-18 to reflect a balanced scorecard approach to performance and organizational priorities.

The performance measures are linked to the Alberta Quality Matrix for Health, which describes six dimensions of quality.

Acceptability	Health services are respectful and responsive to user needs, preferences and expectations.
Accessibility	Health services are obtained in the most suitable setting in a reasonable time and distance.
Appropriateness	Health services are relevant to user needs and are based on accepted or evidence-based practice.
Effectiveness	Health services are based on scientific knowledge to achieve desired outcomes.
Efficiency	Resources are optimally used in achieving desired outcomes.
Safety	Mitigate risks to avoid unintended or harmful results.

PERFORMANCE MEASURES

PERFORMANCE MEASURES	2013-14*	2014-15	2015-16	Target 2015-16	Target 2016-17	National Comparison**
Acceptability						
Satisfaction with Hospital Care: The percentage of adult patients who rated their overall care in hospital as 8, 9 or 10, where zero is the lowest level of satisfaction possible and 10 is the best.	82%	82%	82% Q3 YTD	84%	85%	National comparison not available
Satisfaction with Long-Term Care: The percentage of families of long-term care residents who rated the overall care as 8, 9 or 10, where zero is the lowest level of satisfaction possible and 10 is the best.	Reported by Health quality of Council of Alberta in 2007 as 71%, and 2010 as 73%.	72%	n/a	78%	Not reported until 2018-19	National comparison not available
Safety						
Hospital-Acquired Clostridium difficile Infections: The number of Clostridium difficile infections (C-diff) acquired in hospital every 10,000 days of care. A rate of 4.0 means approximately 100 patients per month acquire C-diff infections in Alberta.	4.4	3.5	3.6 Q3 YTD	4.0	3.3	Alberta ranked better than national results
Hand Hygiene: The percentage of times health care workers clean their hands during the course of patient care.	66%	73%	80%	80%	90%	National comparison not available
Hospital Mortality: The actual number of deaths compared to the expected number of deaths in hospital. Values less than 100 mean fewer than expected deaths in Alberta.	95	93	93 Q3 YTD	n/a*	90	Alberta ranked 3rd best nationally (out of 10 provinces)
Accessibility						
Emergency Department Wait to see a Physician: The average patient's length of time in emergency department before being seen by a physician at the busiest emergency departments.	1.3 hours	1.4 hours	1.3 hours	1.2 hours	1.2 hours	Alberta ranked 4th best nationally (out of 5 provinces)
Emergency Department Length of Stay for Admitted Patients: The average patient's length of time in the emergency department before being admitted to a hospital bed at the busiest emergency departments.	8.6 hours	9.9 hours	9.4 hours	8.2 hours	9.3 hours	Alberta ranked 3rd best nationally (out of 5 provinces)
Emergency Department Length of Stay for Discharged Patients: The average patient's length of time in the emergency department before being discharged at the busiest emergency departments.	3.0 hours	3.2 hours	3.1 hours	2.8 hours	3.1 hours	Alberta ranked 4th best nationally (out of 5 provinces)

PERFORMANCE MEASURES	2013-14	2014-15	2015-16	Target 2015-16	Target 2016-17	National Comparison**
Access to Radiation Therapy: The length of time or less that 9 out of 10 patients wait to receive radiation therapy.	3.0 weeks	3.1 weeks	2.9 weeks	2.6 weeks	2.6 weeks	Alberta ranked 3rd best nationally (out of 9 provinces)
Children's Mental Health Access: Percent of children (age 0-17 years) offered scheduled community mental health treatment within 30 days from referral.	87%	89%	85%	90%	90%	National comparison not available
Appropriateness						
Continuing Care Placement: The percentage of people placed into continuing care within 30 days of being referred.	69%	60%	60%	70%	62%	National comparison not available
Efficiency						
Acute (Actual) Length of Hospital Stay Compared to Expected Stay: The actual length of stay in hospital compared to the expected length of stay in hospital. Every .01 drop in this ratio means we can treat over 3,200 more patients in hospital every year.	1.03	1.02	1.00	n/a*	0.98	Alberta ranked 3rd best nationally (out of 9 provinces)
Effectiveness						
Early Detection of Cancer: The percentage of patients with breast, cervical and colorectal cancers who are diagnosed at early stages.	66% (2011) 67% (2012) 68% (2013) 69% (2014)		n/a	70%	70%	Alberta ranked 2nd best nationally for breast cancer and 8th for colorectal cancer (out of 9 provinces)
Mental Health Readmissions: The percentage of mental health patients with unplanned readmission to hospital within 30 days of leaving hospital.	8.9%	8.8%	8.5% Q3 YTD	n/a*	8.5%	Alberta ranked 2nd best nationally (out of 10 provinces)
Surgery Readmissions: The percentage of surgical patients with unplanned readmission to hospital within 30 days of leaving hospital.	6.7%	6.5%	6.6% Q3 YTD	6.3%	6.3%	Alberta ranked 5th best nationally (out of 10 provinces)
Heart Attack Mortality: The percentage of patients dying in hospital within 30 days of being admitted for a heart attack.	7.2%	6.2%	6.2% Q3 YTD	5.9%	5.9%	Alberta ranked 4th best nationally (out of 10 provinces)
Stroke Mortality: The percentage of patients dying in hospital within 30 days of being admitted for a stroke.	14.1%	13.9%	14.8% Q3 YTD	13.2%	13.2%	Alberta ranked 4th best nationally (out of 10 provinces)

**The 2015-16 targets were established using previous definitions; the 2016-17 targets reflect CIHI adjustments on how patients are categorized based on diagnosis and complexity.*

***National Comparisons are based on 2014-15 data and information provided by the Canadian Institute for Health Information (CIHI). However, the analyses, conclusions, opinions and statements expressed herein are not necessarily those of the CIHI. Source for Early Detection of Cancer is the Canadian Community Health Survey (CCHS) for 2012.*

CONCLUSION

Alberta Health Services will continue to focus on strengthening public health and primary care, improving access and flow, and enhancing community-based options. We are working to address the pressures of a growing and aging population and the uncertainty of the current provincial financial situation. At the same time, we strive to ensure our health care services and workforce are the right fit for the needs of Alberta's population.

We are undertaking some changes that will help the health care system become stronger and more sustainable. We will continue to improve efficiency throughout the system to ensure AHS gets the maximum value from every health dollar. Ensuring we are using operational best practices will also guide future planning and will determine what we need to do to improve our qualitative and quantitative information. Through all of this change, AHS will continue to provide health care with the strength and advantages of a provincewide health system, so Albertans get the right care in the right place.

As we move toward our strategic goals and objectives, evidence and research will support and inform the decisions we make and help us assess how we are doing and manage the changes necessary to continue to improve how we serve Albertans.

Our hard-working and dedicated AHS staff, physicians and volunteers are the cornerstone of this organization, as we work to fulfil the strategic goals and objectives outlined in the 2016-17 AHS Health Plan and Business Plan.

2016-17 Business Plan

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Overview

The 2016-17 Business Plan supports the Health Plan and the four AHS goals of building a culture of patient-, family-, and community-centred care to improve patient experience, improving health outcomes through clinical best practices, ensuring our people feel safe, healthy, and valued, and achieving financial sustainability through operational best practices. The Business Plan describes how we will use our resources to support these four goals and the associated foundational strategies. Not only must AHS support current services that meet the health care needs of Albertans, but we must also target new resources to address unmet clinical needs and service pressures, strategic priorities, and enterprise risks.

To do this, AHS must maximize benefits from investments while managing available resources. Financial sustainability is an important priority as we plan for future service needs within the context of the AHS and provincial fiscal outlook. The Business Plan focuses on achieving a high quality and sustainable health service delivery system for Albertans.

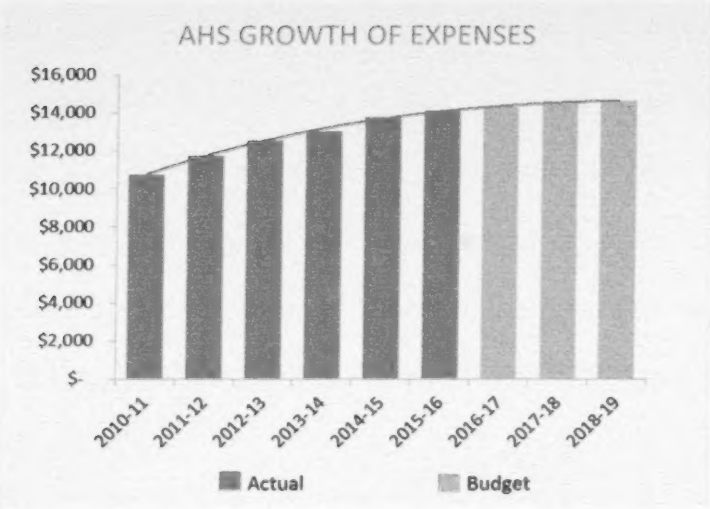
Financial Sustainability

The main cost drivers for AHS expenditures are:

- Growing Population: the population of Alberta has been increasing rapidly and with this increase has come a growing demand for health care services.
- Population is Living Longer: Alberta's aging population is living longer. Although Alberta's population is relatively younger than many other Canadian provinces, an increasing number of Albertans need continuing care services, including elderly residents and residents with special needs such as persons with developmental disabilities and dementia.
- Increased Use of Services: on average, we are using more care per person compared to previous generations. The rising burden of illness associated with chronic health conditions, addiction and mental health needs, and other factors contribute to this increase in service utilization rates and increased demand for health care services.
- Inflation and Increased Cost per Unit: health care costs have been rising more rapidly than general inflation and our costs per unit of service have been increasing. Reporting by the Canadian Institute for Health Information indicates our costs per unit of service are, in some cases, higher than other provinces.

Did You Know?

- Since the formation of AHS, a number of efficiencies have been implemented and AHS has begun to slow the rate of increase in spending while maintaining a focus on delivering high quality health care services.
- Historically, AHS' expenses have grown by over 6 percent per year.
- In 2015/16, actual expenses grew by 2 percent
- For 2016-2019, expenses are budgeted to grow by an average of 1.7 percent per year.
- Health consumes 40 percent of the provincial budget in Alberta and AHS accounts for 70 percent of this amount.



Since AHS was formed, a number of initiatives have been implemented to achieve administrative efficiencies and reduce spending growth including renegotiating supply contracts, administrative restructuring, managing the operating costs of new facilities, and reducing areas of duplication and waste. As a result of these initiatives, the rate of growth has slowed.

In the past 6 years, AHS has also provided funding and implemented many initiatives to meet health service needs across the province. Between April 2010 and March 2016, AHS has invested $350 million to open 5,247 continuing care spaces to support individuals who need community-based housing, care, and supports. Investments have also been made in new facilities, including the South Health Campus, Kaye Edmonton Clinic, Strathcona Hospital, Chinook Regional Hospital, and others. Work is underway to project future needs for addiction and mental health services and planning is also underway for future cancer care services. Funding has been provided to promote patient flow, timely access to services, and the establishment of Strategic Clinical Networks (SCNs) to identify and implement clinical best practices.

The Challenge

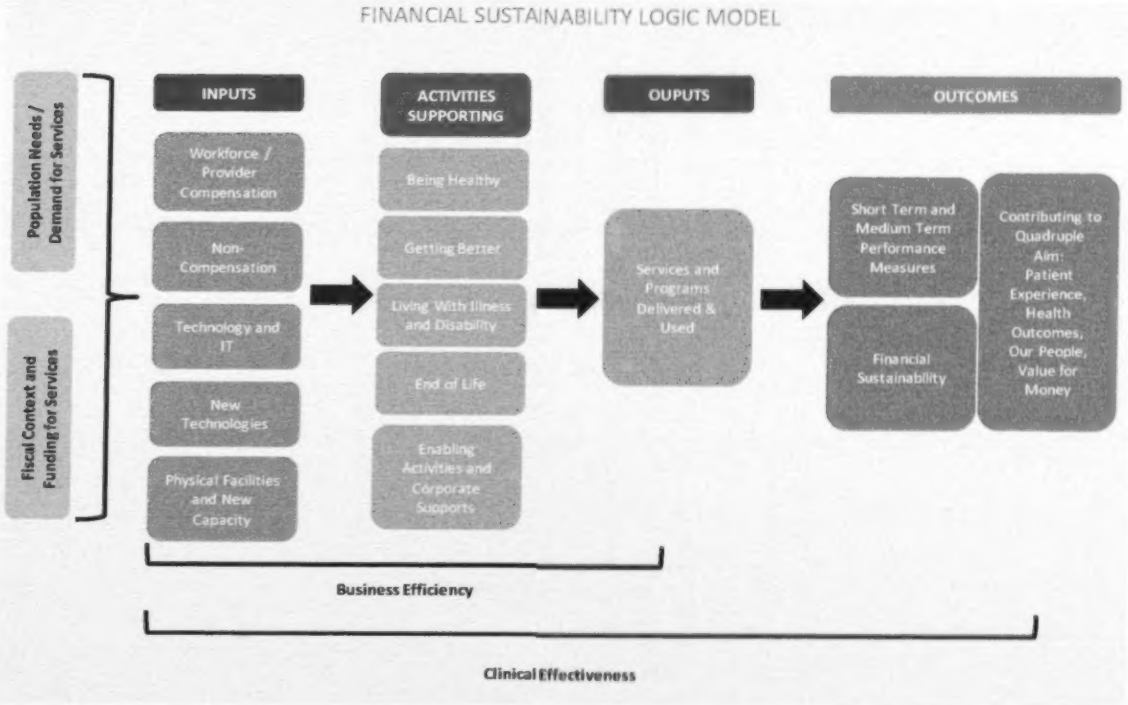
While many investments and efficiencies have been achieved, our costs are higher than the national average. The Canadian Institute for Health Information reports that Alberta public per capita spending on health care is the second highest of all provinces. In 2013, Alberta age-adjusted public spending per person was $5,210, compared with a Canadian average of $3,914 (Canadian Institute for Health Information). Moreover, the average cost of a hospital stay in Alberta is the highest in Canada at $7,580 per hospital stay compared to the Canadian average of $5,632. Input costs are higher in Alberta than many other provinces and our mix of services is more heavily weighted to acute care and specialty services than community and continuing care.

Recognizing the overall provincial fiscal climate and the economic challenges facing Albertans, it is essential that we continue our efforts to manage costs and maximize the benefits achieved within available resources. We have made progress in slowing the rate of increase in costs, but we continue to see variation in cost per unit of service and the use of services across the province. Despite higher spending per capita, AHS' health outcomes are, in many cases, no better than the national average. To support future financial sustainability and improve patient experience and health outcomes, we need to ensure the best results are achieved.

The goal of the 2016-17 Business Plan is to ensure AHS' resources (staff, facilities and equipment, and financial) are used to maximize benefits and to achieve the best results – timely, high quality, patient-centred, and effective health services and patient outcomes. To do so, we are proposing to invest in priority services to meet clinical needs, address service pressures, implement strategic innovations, and address enterprise risks. As well, we are proposing to find efficiencies in order to free up resources for these investments. These efficiencies and strategic investments are described below.

Finding Efficiencies

In order to support these investments and continue to bend the cost curve, AHS is committed to implementing business efficiencies that will free up resources to reallocate to priorities. The AHS financial sustainability model describes how we plan to manage our inputs and activities to increase services and improve short, medium, and long-term outcomes for Albertans.



In the short-term, AHS will focus on achieving business efficiencies. Continuing work underway since AHS was formed, we will continue to identify and eliminate waste, while maintaining or improving quality. We are continuing this work, learning from the experiences of peer organizations both within Alberta and in other provinces. This allows us to identify operational best practices and learn from leaders who have high quality health care services and good health outcomes, but more efficient operations. This work focuses on both supply and compensation related costs at our largest acute care sites, clinical support services (laboratory services, diagnostic imaging, pharmacy, linen and environmental services, and nutrition and patient food services), and corporate services. Additional areas will undertake operational best practices work in the coming years.

In the medium-term, AHS will continue to achieve business efficiencies and augment this with a focus on clinical efficiency and appropriateness. Again, learning from best practice experiences within Alberta and other jurisdictions, quality improvement processes, and research-based evidence, AHS will identify unwarranted variations in practice, variations that do not support effective patient/resident outcomes, and implement clinical pathways to promote effective patient care, effective transitions in care and the best outcomes for our patients and residents. This work will contribute to reducing adverse events or complications, reducing readmissions, and coordinating care.

In the longer-term, AHS will continue work already underway to promote population health and wellness for all residents of Alberta. Whether it is health promotion, disease prevention or effective self-management of chronic conditions, our focus is to support health and wellness for all Albertans.

Consistent with Operational Best Practices, and learning from high-performing organizations, the AHS foundational strategies for Clinical Health Research, Innovation and Analytics and Information Management/Information Technology support this approach, including using health information, increasing our analytics capacity, and reporting on results achieved with investments.

Strategic Investments

In 2016-17, AHS has $461 million of incremental funds available to invest in the health care system, including $365 million of additional revenues and $96 million of efficiencies allowing for funds to be reallocated to the highest priorities. AHS is committed to implementing Operational Best Practices and achieving business efficiencies to support financial sustainability. These initiatives are key to ensuring we manage within available resources and we re-direct our resources to new investments such as the ones identified below.

$128 million of this funding is required to continue current operations including funding negotiated collective bargaining increases for staff and rate increases for clinical contract providers and the remaining $333 million will be used to make new strategic investments. These investments will allow AHS to achieve specific outcomes, including increasing quality, expanding access, and achieving efficiencies and are aligned with the goals outlined in the Health Plan. The implementation of these initiatives is dependent on the implementation of Operational Best Practices. As a result, the timing of new investments may be adjusted to ensure that AHS is achieving a balanced financial position in 2016-17. The following is an overview of the allocation of funding and outcomes to be achieved.

Goal 1: Build a Culture of Patient-Centred Care to Improve Experience

Providing appropriate community-based health care options continues to be a priority for Alberta Health and AHS. AHS plans to allocate $61 million to add a projected 950 net new spaces, including long-term care and designated supportive living, to the system in 2016-17. This will reduce demand for hospital beds and emergency departments and add overall capacity to the health care system.

AHS will add $105 million on an annualized basis towards initiatives that expand home care services, strengthen addiction and mental health services, expand cancer services, implement clinical care pathways, and increase the number of courses of care delivered by midwives in Alberta. Investments in home care and addiction and mental health services support the priorities identified by Alberta Health and will allow more Albertans to avoid hospital admissions and stay in their homes and communities. Additional restricted grant funding from Alberta Health will also be provided to increase the number of detox beds available to treat alcohol or drug disorders, and to fund the implementation of the Opioid Dependency Treatment Service Delivery model, providing treatment for patients with opioid dependencies including fentanyl. Cancer services will be expanded in regional and community care centres, increasing capacity for radiation therapy treatment for curative and palliative care and will reduce wait times for patients and reduce the distance that patients have to travel for care. AHS will also increase the courses of care delivered by midwives in Alberta, thereby increasing access to this valuable maternity service.

SCNs are leading AHS development and implementation of clinical care pathways, reducing variation in practice, improving outcomes and scaling and spreading innovation. Specifically, AHS is developing care pathways for intensive care unit delirium, chronic obstructive pulmonary disease, breast cancer, diabetes management and congestive heart failure. The Kidney SCN will be advancing important pathway work that will look at ways to optimize dialysis therapies across Alberta with a focus on peritoneal and home based approaches. In doing so, AHS will be able to improve province wide performance while monitoring outcomes for kidney patients. In 2016-17, AHS is investing up to $7 million to support SCN initiatives, including the development of these pathways, which will in return reduce mortality rates, reduce the length of stay in hospital, and improve the overall patient experience.

Goal 2: Health Outcomes and Clinical Best Practice

Population growth, increased demand for health services, and aging health infrastructure continue to challenge how AHS will deliver services in the future. In 2016-17, AHS will invest $90 million on an annualized basis to address these challenges including funding $50 million for operating costs of new health care facilities across the province including the Edson Health Care Centre, the Northern Alberta Urology Centre, the Stollery Critical Care Unit, the Red Deer Obstetrical Unit, the Chinook Regional Hospital Redevelopment, the High Prairie Health Complex, and the Medicine Hat Regional Hospital Redevelopment. These facilities will ensure quality and safe care is provided to Albertans.

In addition, AHS will invest $40 million to respond to increased demand for surgical services, primary care services in the North Zone and expanding the colorectal and other Enhanced Recovery after Surgery (ERAS) pathways into additional acute care sites. This funding will also support the implementation of a Shared Patient Equipment Cleaning Program for equipment shared between patients or used to provide care for more than one patient, such as IV poles, scales, and stethoscopes. These initiatives will decrease wait times and improve patient satisfaction, increase emphasis of health promotion, reduce readmission rates, and prevent healthcare-acquired infections.

Goal 3: Our People

AHS is committed to creating a culture in which we all feel safe, healthy, and valued, and can reach our full potential. Under the Our People Strategy, there are a number of specific deliverables to improve the engagement levels of the physician, employee, and volunteer workforce by creating a safe, healthy, and inclusive place to work.

The 2016-17 budget invests $2 million towards initiatives that measure the success of the deliverables through annual workforce engagement surveys and programs to demonstrate cultural competency and sensitivity and support mental health in the workplace. Part of this investment will also include the expansion of the AHS Occupational Health program, specifically to enable the requirements of the recently approved Mandatory Communicable Disease Assessment Policy. This initiative is directly tied to the Workplace Health and Safety component of the AHS Enterprise Risk Registry and will improve the overall management of outbreaks and decrease staff absenteeism.

Goal 4: Financial Health and Operational Best Practice

$196 million of funding is available in 2016-17 to support the requirements to continue current operations as well as initiatives that support the financial health of AHS.

In 2016-17, AHS has committed $128 million to fund workforce compensation rate changes, clinical contract inflation, and physician medical fee increases. Salaries and benefits and contracts with health service providers are the organization's highest and second highest expenses and are therefore significant cost drivers for AHS.

AHS will invest in the expansion of the Business Continuity Management Program to mitigate risk associated with the loss or interruption of any of the requirements for healthcare delivery, and in reducing variation in funding by transitioning towards a provincial interim funding model for designated supportive living sites.

In addition, funds will be allocated to support the foundational requirements to implement a provincial Clinical Information System, including the development of provincial standards for clinical information and knowledge, implementing wireless infrastructure, and hiring project staff. The Alberta Government and AHS are working together to finalize funding requirements over the next 10 years, including both operating and capital requirements. This initiative will integrate existing technologies and help standardize data to support the flow of information across the health system, allowing for better patient outcomes and improved access to clinical data for analysis and research.

Key Risks

AHS has an Enterprise Risk Management (ERM) program which actively monitors and manages risks that may impact the achievement of its strategic directions. Priority strategic risks for AHS are:

- Patient Safety (adverse events);
- Appropriateness of Care (patient transitions and navigation);
- Patient Experience (patient satisfaction);
- Financial Sustainability;
- Business Continuity Management (emergency / disaster management).

Mitigation plans have been developed for each risk to guide management activities.

In addition to the priority strategic risks, the following risks are specific to the budget. AHS will actively manage these risks and implement mitigation strategies. These risks include:

Unmet clinical needs: AHS has identified unmet clinical needs in clinical areas ranging from Aboriginal Health to Surgical Services. Unmet clinical needs include:

- Activity driven service pressures arising from greater demand for services than current capacity supports;
- Areas with wait lists for service that impact patient outcomes and quality of care;
- Unmet needs for specific population segments that may be under-served or not currently access health services;
- Clinical services and programs that are not able to achieve performance targets.

These clinical needs may result in unfunded cost pressures. To mitigate this risk, AHS will expand capacity in areas such as continuing care and home care and will implement strategic initiatives such as enhancing system flow and improving surgical capacity management.

Cost inflation: Expenses may be higher than anticipated due to increased cost inflation in areas such as compensation, drugs, medical and surgical supplies, and contracted services. AHS is working on initiatives to mitigate inflationary cost increases, including:

- Reviewing performance on efficiency and productivity measures in comparison with peers in other provinces;
- Reviewing supplies contracts and bulk purchasing opportunities;
- Using standard formularies in areas such as office supplies and medical devices.

Capital: AHS has over $7.5 billion in tangible capital assets. Inadequate or outdated capital equipment may hinder AHS' ability to provide timely, appropriate care, to meet quality standards and provide a safe and efficient physical environment. AHS had an identified backlog of deferred facility maintenance of approximately $783 million as of March 2015. AHS has aging equipment in key areas such as cancer radiation therapy equipment and ambulances. As equipment ages, maintenance requirements and downtime increases or equipment can become obsolete due to clinical requirements for new technologies.

AHS will continue to focus its capital spending on the highest priorities and work closely with Alberta Infrastructure and Alberta Health on capital planning. The 2016-17 budget includes $131 million of funding to support the Infrastructure Maintenance Program which will help address the maintenance backlog mentioned below.

2016-17 Budget Allocation

- $3,008 million for continuing care, community care, and home care, a 7.0 percent increase over 2015-16.
- $4,881 million for acute care operations, a 2.2 percent increase over 2015-16.
- $5,971 million for programs required to support direct patient care such as ambulances services, diagnostic and therapeutic services, information systems, facilities maintenance, linen and environmental services, food and nutrition services, and other patient care support services, a 1.0 percent increase over 2015-16.
- $458 million for administration, a 0.9 percent increase over 2015-16.

2016-17 Budget Overview

AHS is proposing a balanced operating budget as follows:

(in millions)	2016-17 Budget	2015-16 Budget	Difference	
Base operating grant from Alberta Health	11,718	11,330	388	3.4%
Restricted grants transferring into base operating grant[1]	142	142	-	-
Sub-total base operating grant from Alberta Health	11,860	11,472	388	3.4%
Other operating grants from Alberta Health	968	968	-	-
Other revenue	1,490	1,513	(23)	(1.5%)
Total revenue	14,318	13,953	365	2.6%
Total expenses	14,318	13,953	365	2.6%
Operating surplus / (deficit)	-	-	-	-

These budgeted financial statements have been prepared using consistent accounting policies and should be read in conjunction with the AHS annual audited consolidated financial statements and notes thereto.

The AHS budgeted financial statements are prepared on a consolidated basis and include the following:

- 3 wholly owned subsidiaries: Calgary Laboratory Services Ltd., Capital Care Group Inc., and Carewest;
- 32 controlled foundations;
- Provincial Health Authorities of Alberta Liability and Property and Insurance Plan and the Queen Elizabeth II Hospital Child Care Centre; and
- 50 percent interest in the 42 Primary Care Networks, 50 percent interest in the Northern Alberta Clinical Trials Centre joint venture, and 30 percent interest in the HUTV Limited Partnership.

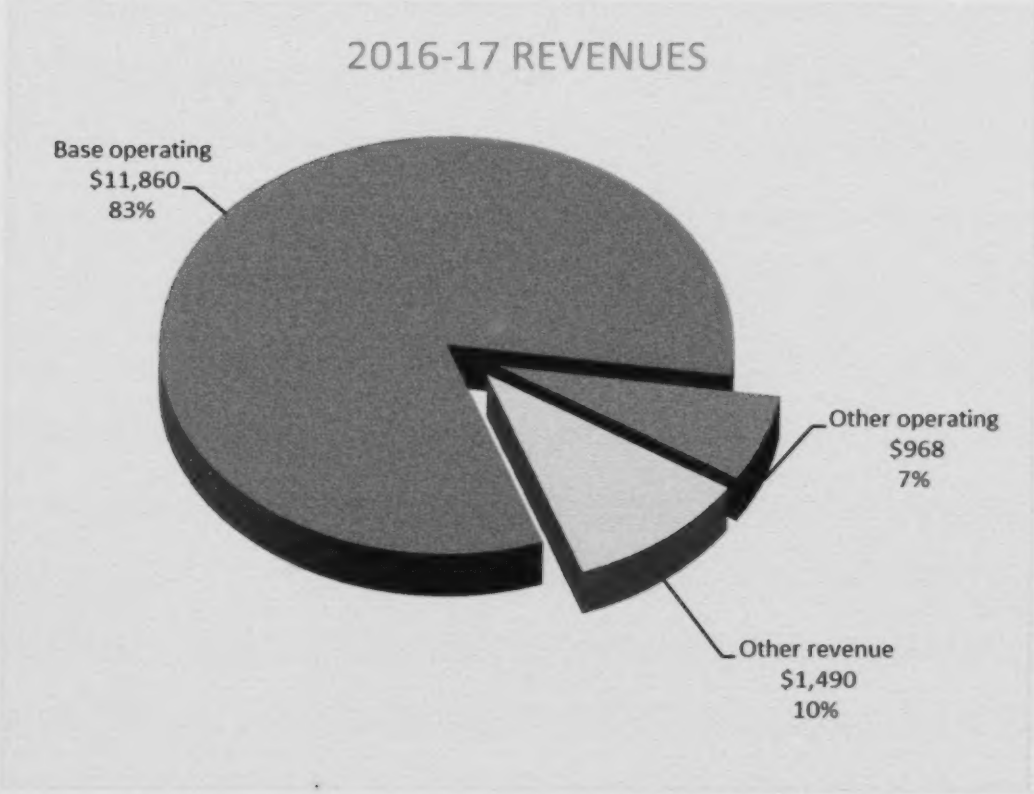
[1] The 2015-16 Budget has been restated to reflect the transfer of $142 million of other operating grants to the base operating grant in 2016-17.

Revenue

In 2016-17, total revenue will be $14,318 million, an increase of 2.6% percent, or $365 million over the 2015-16 budget .

AHS operating revenue primarily consists of the base operating grant and restricted grants from Alberta Health. The base operating grant from Alberta Health will be $11,860 million, which includes the base operating grant and a $142 million of restricted grants that have now been transferred to the base operating grant. Other operating grants will be $968, with no increase from prior year and include restricted grants to support specialized drugs, alternate relationship plans with physicians, and Primary Care Networks.

Other revenue includes federal and provincial (excluding Alberta Health) government contributions, investments, donations from foundations, trusts and individuals as well as revenue from ancillary operations such as parking, non-patient food services and sale of goods and services. Other revenue will be $1,490 million, a decrease of 1.5 percent or $23 million, primarily due to decreases in budgeted amortization.



Expenses

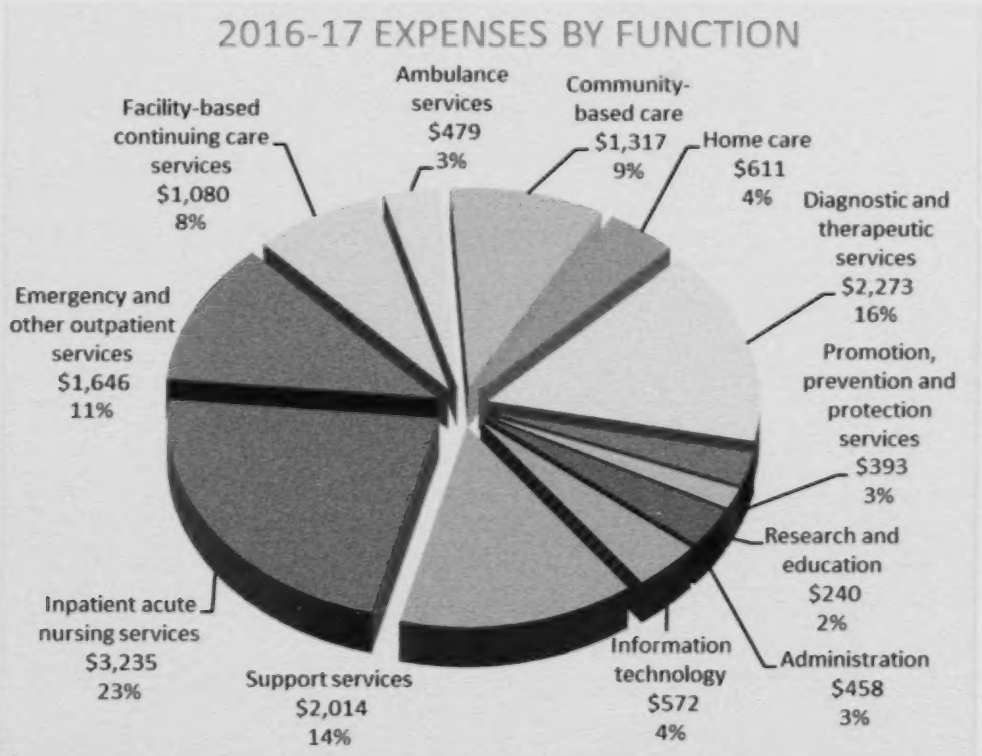
In 2016-17, total expenses will be $14,318 million, an increase of 2.6% percent or $365 million over the 2015-16 budget which will allow AHS to fund requirements to continue current operations (such as compensation inflation) and invest in unmet clinical needs and service pressures, strategic priorities, and enterprise risks.

In 2016-17, AHS will spend approximately $39 million per day to support the health care system in Alberta.

Expenses by Function

AHS reports its costs by functional categories that are consistent with guidelines established by the Canadian Institute for Health Information. These categories facilitate consistent, comparable reporting across jurisdictions.

Budgets for the majority of expenses by function are increasing as a result of collective bargaining agreements, medical fee increases, and increases related to the implementation of priority new investments. The majority of the increases in 2016-17 have been directed to continuing care and community care services, including home care. These functions (facility-based continuing care services, community-based care, and home care) are increasing by 7.0 percent over the 2015-16 budget primarily due to investments in the Continuing Care Capacity Plan, home care, and addiction and mental health. Acute care services (inpatient acute nursing services and emergency and other outpatient services) are increasing by 2.2 percent, primarily due to the increases required to support the opening of new acute care facilities and increased surgical capacity. Budget for administration is increasing by $4 million or 0.9 percent due to collective bargaining agreements and to support the implementation of priority new investments. Administration is composed of human resources, finance, communications, planning and development, infection control, quality assurance, patient safety, insurance, privacy, risk management, internal audit, legal, and senior executive.

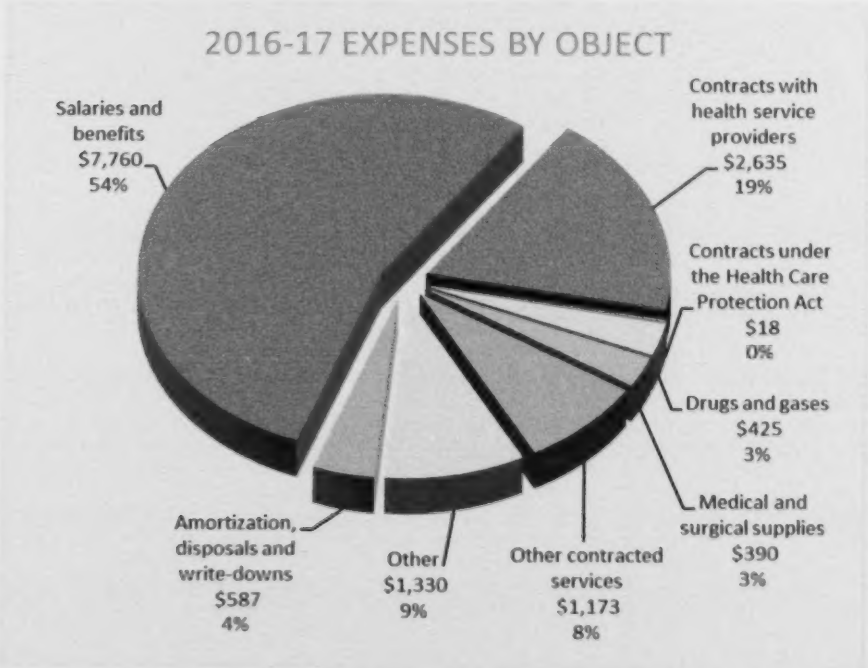

2016-17 EXPENSES BY FUNCTION
Facility-based continuing care services $1,080 8%
Ambulance services $479 3%
Community-based care $1,317 9%
Home care $611 4%
Diagnostic and therapeutic services $2,273 16%
Promotion, prevention and protection services $393 3%
Research and education $240 2%
Administration $458 3%
Information technology $572 4%
Support services $2,014 14%
Inpatient acute nursing services $3,235 23%
Emergency and other outpatient services $1,646 11%

Expenses by Object

Salaries and benefits represent the largest expense at $7,760 million or 54% percent of total expenses, including $6,374 million for salaries and $1,386 million for benefits. Physician fees and purchased services are reported under other contracted services and only represent a small portion of physician costs in Alberta. The majority of physician costs are funded directly by Alberta Health through fee for service payments.

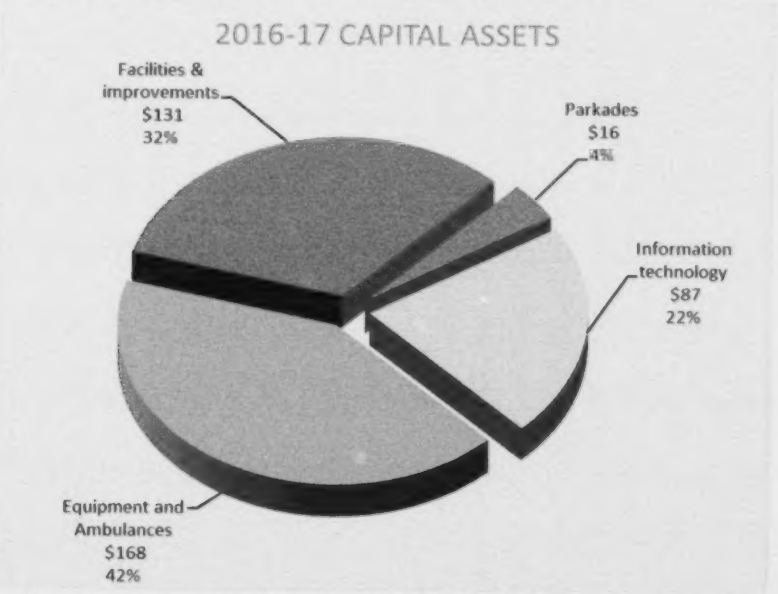
Salaries and benefits are increasing by 2.0 percent, primarily due to workforce compensation rate changes. Management and out of scope staff salaries will remain frozen for 2016-17 as announced by the Government of Alberta. Salaries and benefits are also increasing due to staffing required to support the opening of new facilities and other priority new investments.

All other expenses include clinical and corporate contracts, drugs and gases, medical surgical supplies, and other expenses. These expenses will be $6,558 million, an increase of 3.4% percent or $216 million over the 2015-16 budgeted expenses, primarily due to clinical contract inflation and increases related to priority new investments.


2016-17 EXPENSES BY OBJECT
Salaries and benefits $7,760 54%
Contracts with health service providers $2,635 19%
Contracts under the Health Care Protection Act $18 0%
Drugs and gases $425 3%
Medical and surgical supplies $390 3%
Other contracted services $1,173 8%
Other $1,330 9%
Amortization, disposals and write-downs $587 4%

Capital Assets

AHS' capital budget for 2016-17 is $402 million. This includes $200 million of tangible capital assets purchased with internal funds and $202 million purchased with external funds, reserve funds, and debt.


2016-17 CAPITAL ASSETS
Facilities & improvements $131 32%
Parkades $16 4%
Information technology $87 22%
Equipment and Ambulances $168 42%

Facilities, medical equipment, and information technology are integral to AHS' clinical and business processes and are key enablers for innovation and transformation. Key investments in 2016-17 include:

- Equipment purchases and replacements in areas such as cancer care, diagnostic imaging, and ambulances;
- Facility enhancements and upgrades to maintain clean and healthy environments where infection control standards are met and facilities are maintained to provide a comfortable atmosphere; and
- Information technology investments in equipment, infrastructure and systems including wireless access coverage, network upgrades to enhance sustainability, and reliable clinical information system upgrades.

The following 2016-17 capital investments support the Health Plan and will help to improve health outcomes:

- Replacement of 2 linear accelerators (linacs) used in radiation therapy for cancer patients. This is part of a multi-year plan to replace aging radiation therapy equipment to support the provision of state-of-the-art care and minimize wait times to achieve optimal health outcomes for cancer patients.
- Acquisition of equipment for the Early Hearing Detection and Intervention Program. Two to three infants per thousand are born with permanent congenital hearing impairment. Early detection and intervention enables mitigation of deficits in speech and language, cognition, social, emotional, literacy, and academic skills.
- Continue to implement wireless services in AHS' acute care facilities to provide clinical staff with access to the AHS network through existing and future wireless dependent technologies.

The Government of Alberta will make significant investments in health capital infrastructure during the 2016–21 period:

- $3.5 billion for major capital projects. This includes $1.2 billion to begin work on the Calgary Cancer Centre which is integral to meeting the rising need for cancer care across the province and providing world-class cancer treatment for patients and families in Calgary and Southern Alberta.
- $760 million for capital maintenance and renewal initiatives at health care facilities.

CONSOLIDATED BUDGETED FINANCIAL STATEMENTS
(millions of dollars)

MULTI YEAR OUTLOOK YEARS ENDED MARCH 31	2016 Budget (Note 3a)	2017 Budget	2018 Outlook	2019 Outlook
Revenue:				
Alberta Health transfers				
Base operating	$ 11,472	$ 11,860	$ 12,063	$ 12,206
Other operating	968	968	968	968
Capital	84	81	74	74
Other government transfers	416	408	396	396
Fees and charges	507	513	524	524
Ancillary operations	132	133	134	135
Donations, fundraising, and non-government contributions	166	150	152	147
Investment and other income	208	205	210	198
TOTAL REVENUE	13,953	14,318	14,521	14,648
Expenses:				
Inpatient acute nursing services	3,157	3,235	3,235	3,261
Emergency and other outpatient services	1,619	1,646	1,663	1,686
Facility-based continuing care services	1,047	1,080	1,121	1,137
Ambulance services	468	479	488	486
Community-based care	1,222	1,317	1,411	1,465
Home care	542	611	668	688
Diagnostic and therapeutic services	2,248	2,273	2,261	2,261
Promotion, prevention, and protection services	379	393	406	408
Research and education	240	240	240	240
Administration	454	458	460	459
Information technology	566	572	564	559
Support services	2,011	2,014	2,004	1,998
TOTAL EXPENSES (Schedule 1)	13,953	14,318	14,521	14,648
ANNUAL OPERATING SURPLUS (DEFICIT)	-	-	-	-
Endowment contributions and reinvested income	-	-	-	-
ANNUAL SURPLUS (DEFICIT)	$ -	$ -	$ -	$ -

The accompanying notes and schedule are part of these consolidated budgeted financial statements.

CONSOLIDATED BUDGETED FINANCIAL STATEMENTS
(millions of dollars)

CONSOLIDATED STATEMENT OF OPERATIONS
YEARS ENDED MARCH 31

	2017 Budget	2016 Budget (Note 3a)	Change	% Change
Revenue:				
Alberta Health transfers				
Base operating	$ 11,860	$ 11,472	$ 388	3.4%
Other operating	968	968	-	-
Capital	81	84	(3)	(3.6%)
Other government transfers	408	416	(8)	(1.9%)
Fees and charges	513	507	6	1.2%
Ancillary operations	133	132	1	0.8%
Donations, fundraising, and non-government contributions	150	166	(16)	(9.6%)
Investment and other income	205	208	(3)	(1.4%)
TOTAL REVENUE	14,318	13,953	365	2.6%
Expenses:				
Inpatient acute nursing services	3,235	3,157	78	2.5%
Emergency and other outpatient services	1,646	1,619	27	1.7%
Facility-based continuing care services	1,080	1,047	33	3.2%
Ambulance services	479	468	11	2.4%
Community-based care	1,317	1,222	95	7.8%
Home care	611	542	69	12.7%
Diagnostic and therapeutic services	2,273	2,248	25	1.1%
Promotion, prevention, and protection services	393	379	14	3.7%
Research and education	240	240	-	-
Administration	458	454	4	0.9%
Information technology	572	566	6	1.1%
Support services	2,014	2,011	3	0.1%
TOTAL EXPENSES (Schedule 1)	14,318	13,953	365	2.6%
ANNUAL OPERATING SURPLUS (DEFICIT)	-	-	-	-
Endowment contributions and reinvested income	-	-	-	-
ANNUAL SURPLUS (DEFICIT)	-	-	-	-
Accumulated surplus, beginning of year[2]	1,156	1,306	(150)	(11.5%)
Accumulated surplus, end of year (Note 2)	$ 1,156	$ 1,306	$ (150)	(11.5%)

The accompanying notes and schedule are part of these consolidated budgeted financial statements.

[2] The balance as at April 1, 2016 has been prepared using the 2015-16 Q3 forecast prepared as of March 7, 2016 as the balance as at March 31, 2016 was not available when the 2016-17 budget was prepared.

CONSOLIDATED BUDGETED FINANCIAL STATEMENTS
(millions of dollars)

CONSOLIDATED STATEMENT OF FINANCIAL POSITION AS AT MARCH 31				
	2017 Budget	2016 Budget (Note 1) (Note 3b)	Change	% Change
Financial Assets:				
Cash	$ 72	$ 75	$ (3)	(4%)
Portfolio investments	2,318	2,430	(112)	(5%)
Accounts receivable	314	314	-	-
Other assets	12	39	(27)	(69%)
	2,716	2,858	(142)	(5%)
Liabilities:				
Accounts payable and accrued liabilities	1,349	1,417	(68)	(5%)
Employee future benefits	588	581	7	1%
Unexpended deferred operating revenue	496	408	88	22%
Unexpended deferred capital revenue	135	171	(36)	(21%)
Debt	381	348	33	9%
	2,949	2,925	24	1%
NET DEBT	(233)	(67)	(166)	248%
Non-Financial Assets:				
Tangible capital assets	7,611	7,836	(225)	(3%)
Inventories for consumption	97	97	-	-
Prepaid expenses	122	117	5	4%
	7,830	8,050	(220)	(3%)
NET ASSETS BEFORE EXPENDED DEFERRED CAPITAL REVENUE	7,597	7,983	(386)	(5%)
Expended deferred capital revenue	6,437	6,654	(217)	(3%)
NET ASSETS	$ 1,160	$ 1,329	$ (169)	(13%)
Net Assets is comprised of:				
Accumulated surplus (Note 2)	$ 1,156	$ 1,306	$ (150)	(11%)
Accumulated remeasurement gains and losses	4	23	(19)	(83%)
	$ 1,160	$ 1,329	$ (169)	(13%)

The accompanying notes and schedule are part of these consolidated budgeted financial statements.

CONSOLIDATED BUDGETED FINANCIAL STATEMENTS
(millions of dollars)

CONSOLIDATED STATEMENT OF CHANGES IN NET DEBT YEARS ENDED MARCH 31	2017 Budget	2016 Budget (Note 1)
Annual surplus (deficit)	$ -	$ -
Effect of changes in tangible capital assets:		
Acquisition of tangible capital assets	(402)	(940)
Amortization, disposals and write-downs of tangible capital assets	587	618
Effects of other changes:		
Net increase (decrease) in expended deferred capital revenue	(217)	290
Net (increase) decrease in inventories for consumption	1	(1)
Net (increase) decrease in prepaid expense	(5)	10
Net remeasurement losses	(19)	(16)
Increase in net debt	(55)	(39)
Net debt, beginning of year[3]	(178)	(28)
Net debt, end of year	$ (233)	$ (67)

CONSOLIDATED STATEMENT OF REMEASUREMENT GAINS AND LOSSES YEARS ENDED MARCH 31	2017 Budget	2016 Budget
Accumulated remeasurement gains, beginning of year[3]	$ 23	$ 39
Unrestricted unrealized net gains (losses) on portfolio investments	(4)	6
Amounts reclassified to the Consolidated Statement of Operations related to portfolio investments	(15)	(22)
Net remeasurement losses for the year	(19)	(16)
Accumulated remeasurement gains, end of year	$ 4	$ 23

The accompanying notes and schedule are part of these consolidated budgeted financial statements.

[3] The balance as at April 1, 2016 has been prepared using the 2015-16 Q3 forecast prepared as of March 7, 2016 as the balance as at March 31, 2016 was not available when the 2016-17 budget was prepared.

CONSOLIDATED BUDGETED FINANCIAL STATEMENTS
(millions of dollars)

CONSOLIDATED STATEMENT OF CASH FLOWS YEARS ENDED MARCH 31	2017 Budget	2016 Budget (Note 3b)
Operating transactions:		
Annual surplus (deficit)	$ -	$ -
Non-cash items:		
Amortization, disposals, and write-downs	587	618
Recognition of expended deferred capital revenue	(403)	(425)
Decrease (increase) in:		
Accounts receivable related to operating transactions	-	-
Inventories for consumption	1	(1)
Other assets	27	(27)
Prepaid expenses	(5)	10
Increase (decrease) in:		
Accounts payable and accrued liabilities related to operating transactions	(18)	276
Employee future benefits	7	(14)
Deferred revenue related to operating transactions	25	(95)
Cash provided by operating transactions	221	342
Capital transactions:		
Acquisition of tangible capital assets	(402)	(412)
(Decrease) in accounts payable and accrued liabilities related to capital transactions	(15)	(116)
Cash applied to capital transactions	(417)	(528)
Investing transactions:		
Purchase of portfolio investments	(4,668)	(3,695)
Proceeds on disposals of portfolio investments	4,634	3,359
Cash applied to investing transactions	(34)	(336)
Financing transactions:		
Restricted capital revenue received	194	256
Proceeds from debt	50	25
Principal payments on debt	(17)	(16)
Cash provided by financing transactions	227	265
Net decrease in cash	(3)	(257)
Cash, beginning of year[4]	75	332
Cash, end of year	$ 72	$ 75

The accompanying notes and schedule are part of these consolidated budgeted financial statements.

[4] The balance as at April 1, 2016 has been prepared using the 2015-16 Q3 forecast prepared as of March 7, 2016 as the balance as at March 31, 2016 was not available when the 2016-17 budget was prepared.

NOTES TO THE CONSOLIDATED BUDGETED FINANCIAL STATEMENTS
MARCH 31, 2017

Note 1 Change in Accounting Policy – Adoption of the Net Debt Model

The net debt model (with reclassification of comparatives) has been adopted for the presentation of the budgeted financial statements consistent with the presentation of the March 31, 2016 annual audited consolidated financial statement. Budgeted net financial asset or net debt is measured as the difference between AHS' budgeted financial assets and liabilities.

A net debt balance indicates the extent of AHS' dependence on net assets from government transfer and operating revenues in order to settle its liabilities.

The effect of this change has resulted in a change in the presentation of the Consolidated Statement of Financial Position and the inclusion of the Consolidated Statement of Changes in Net Debt.

Note 2 Accumulated Operating Surplus

Accumulated operating surplus is comprised of the following:

	Unrestricted surplus [a]	Internally restricted surplus for future purposes[b]	Invested in tangible capital assets	Endowments	Total
Balance as at March 31, 2016[5]	$ 172	$ 149	$ 760	$ 75	$ 1,156
Annual surplus (deficit)	-	-	-	-	-
Tangible capital assets purchased with internal funds	(190)	-	190	-	-
Amortization of internally funded tangible capital assets	184	-	(184)	-	-
Repayment of debt used to fund tangible capital assets	(17)	-	17	-	-
Transfer of internally restricted surplus for future purposes	(83)	83	-	-	-
Transfer of endowment contributions	-	-	-	-	-
Balance as at March 31, 2017	$ 66	$ 232	$ 783	$ 75	$ 1,156

(a) Unrestricted Surplus

Unrestricted surplus represents the portion of accumulated surplus that has not already been invested in tangible capital assets or internally restricted for future purposes.

[5] The balance as at March 31, 2016 has been prepared using the 2015-16 Q3 forecast prepared as of March 7, 2016 as the balance as at March 31, 2016 was not available when the 2016-17 budget was prepared.

NOTES TO THE CONSOLIDATED BUDGETED FINANCIAL STATEMENTS
(millions of dollars)

Note 2 Accumulated Operating Surplus (continued)

(b) Internally Restricted Surplus for Future Purposes

The Board has approved the budgeted restriction of accumulated surplus for future purposes as follows:

	2017 Budget	2016 Budget
Parkade infrastructure[(i)]	$ 87	$ 71
Future capital purposes[(ii)]	45	2
Insurance equity requirements[(iii)]	38	25
Provincial Clinical Information Systems Initiative[(iv)]	26	20
Specific local initiatives[(v)]	17	15
Cancer research[(vi)]	16	16
Retail food services infrastructure[(vii)]	3	-
Internally restricted operating surplus for future purposes	$ 232	$ 149

(i) Restriction of parking services surpluses to establish a parking infrastructure reserve for future major maintenance, upgrades, and construction.
(ii) Restriction of unrestricted surplus related to future capital purposes.
(iii) Restriction of unrestricted surplus related to the equity of the Provincial Health Authorities of Alberta Liability and Property Insurance Plan.
(iv) Restriction of unrestricted surplus related to fund the Provincial Clinical Information System initiative.
(v) Restriction of unrestricted surplus for specific local initiatives as a result of local fundraising.
(vi) Restriction of unrestricted surplus to fund cancer research.
(vii) Restriction of retail food services surplus to assist with future upgrades, maintenance, equipment, and construction costs for retail food service operations.

Note 3 Budget Reclassifications

In 2015-16, AHS reclassified the approved budget due to a change in methodology and to be consistent with the Canadian Institute of Health Information definitions including a change in the expense allocation methodology for contracts with health service providers and changes to align with Alberta Health and Canadian Institute of Health Information standards.

In addition, AHS reclassified a portion of cash, deemed to be held for investment purposes. The reclassified balances are comprised of money market funds held for investing purposes.

SCHEDULES TO THE CONSOLIDATED BUDGETED FINANCIAL STATEMENTS
(millions of dollars)

SCHEDULE 1 – CONSOLIDATED SCHEDULE OF EXPENSES BY OBJECT
YEARS ENDED MARCH 31

	2017 Budget	2016 Budget	Change	% Change
Salaries and benefits	$ 7,760	$ 7,611	$ 149	2%
Contracts with health service providers	2,635	2,409	226	9%
Contracts under the Health Care Protection Act	18	18	-	-
Drugs and gases	425	427	(2)	-
Medical and surgical supplies	390	390	-	-
Other contracted services	1,173	1,164	9	1%
Other	1,330	1,316	14	1%
Amortization, disposals and write-downs	587	618	(31)	(5%)
	$ 14,318	$ 13,953	$ 365	3%

SCHEDULES TO THE CONSOLIDATED BUDGETED FINANCIAL STATEMENTS
(millions of dollars)

SCHEDULE 2 – BUDGET RECLASSIFICATIONS
YEAR ENDED MARCH 31

a) Reconciliation of the Consolidated Statement of Operations

	2016 Budget as previously presented	Budget Reclassifications (Note 3)	2016 Revised Budget
Revenue:			
Alberta Health transfers			
Base operating	$ 11,472	$ -	$ 11,472
Other operating	968	-	968
Capital	84	-	84
Other government transfers	416	-	416
Fees and charges	507	-	507
Ancillary operations	132	-	132
Donations, fundraising, and non-government contributions	166	-	166
Investment and other income	208	-	208
TOTAL REVENUE	13,953	-	13,953
Expenses:			
Inpatient acute nursing services	3,210	(53)	3,157
Emergency and other outpatient services	1,620	(1)	1,619
Facility-based continuing care services	984	63	1,047
Ambulance services	468	-	468
Community-based care	1,227	(5)	1,222
Home care	536	6	542
Diagnostic and therapeutic services	2,329	(81)	2,248
Promotion, prevention, and protection services	376	3	379
Research and education	238	2	240
Administration	450	4	454
Information technology	565	1	566
Support services	1,950	61	2,011
TOTAL EXPENSES (Schedule 1)	13,953	-	13,953
ANNUAL OPERATING SURPLUS (DEFICIT)	-	-	-
Endowment contributions and reinvested income	-	-	-
ANNUAL SURPLUS (DEFICIT)	-	-	-
Accumulated surplus, beginning of year[6]	1,306	-	1,306
Accumulated surplus, end of year (Note 2)	$ 1,306	$ -	$ 1,306

[6] The balance as at April 1, 2016 has been prepared using the 2015-16 Q3 forecast prepared as of March 7, 2016 as the balance as at March 31, 2016 was not available when the 2016-17 budget was prepared.

SCHEDULES TO THE CONSOLIDATED BUDGETED FINANCIAL STATEMENTS
(millions of dollars)

SCHEDULE 2 – BUDGET RECLASSIFICATIONS
YEAR ENDED MARCH 31

b) Reconciliation of the Consolidated Statement of Financial Position

	2016 Budget as previously presented	Budget Reclassifications (Note 3)	2016 Revised Budget
Financial Assets:			
Cash	$ 975	$ (900)	$ 75
Portfolio investments	1,530	900	2,430
Accounts receivable	314	-	314
Other assets	39	-	39
	2,858	-	2,858
Liabilities:			
Accounts payable and accrued liabilities	1,417	-	1,417
Employee future benefits	581	-	581
Unexpended deferred operating revenue	408	-	408
Unexpended deferred capital revenue	171	-	171
Debt	348	-	348
	2,925	-	2,925
NET DEBT	(67)	-	(67)
Non-Financial Assets:			
Tangible capital assets	7,836	-	7,836
Inventories for consumption	97	-	97
Prepaid expenses	117	-	117
	8,050	-	8,050
NET ASSETS BEFORE EXPENDED DEFERRED CAPITAL REVENUE	7,983	-	7,983
Expended deferred capital revenue	6,654	-	6,654
NET ASSETS	$ 1,329	$ -	$ 1,329
Net Assets is comprised of:			
Accumulated surplus (Note 2)	$ 1,231	$ 75	$ 1,306
Accumulated remeasurement gains and losses	23		23
	75	(75)	-
	$ 1,329	$ -	$ 1,329

SCHEDULES TO THE CONSOLIDATED BUDGETED FINANCIAL STATEMENTS
(millions of dollars)

SCHEDULE 2 – BUDGET RECLASSIFICATIONS
YEAR ENDED MARCH 31

c) Reconciliation of the Consolidated Statement of Cash Flows

	2016 Budget as previously presented	Budget Reclassifications (Note 3)	2016 Revised Budget
Operating transactions:			
Annual surplus (deficit)	$ -	-	$ -
Non-cash items:			
Amortization, disposals, and write-downs	618	-	618
Recognition of expended deferred capital revenue	(425)	-	(425)
Decrease (increase) in:			
Accounts receivable related to operating transactions	-	-	-
Inventories for consumption	(1)	-	(1)
Other assets	(27)	-	(27)
Prepaid expenses	10	-	10
Increase (decrease) in:			
Accounts payable and accrued liabilities related to operating transactions	276	-	276
Employee future benefits	(14)	-	(14)
Deferred revenue related to operating transactions	(95)	-	(95)
Cash provided by operating transactions	342	-	342
Capital transactions:			
Acquisition of tangible capital assets	(412)	-	(412)
(Decrease) in accounts payable and accrued liabilities related to capital transactions	(116)	-	(116)
Cash applied to capital transactions	(528)	-	(528)
Investing transactions:			
Purchase of portfolio investments	(3,013)	(682)	(3,695)
Proceeds on disposals of portfolio investments	3,359	-	3,359
Cash applied to investing transactions	346	(682)	(336)
Financing transactions:			
Restricted capital revenue received	256	-	256
Proceeds from debt	25	-	25
Principal payments on debt	(16)	-	(16)
Cash provided by financing transactions	265	-	265
Net decrease in cash	425	(682)	(257)
Cash, beginning of year[7]	550	(218)	332
Cash, end of year	$ 975	(900)	$ 75

[7] The balance as at April 1, 2016 has been prepared using the 2015-16 Q3 forecast prepared as of March 7, 2016 as the balance as at March 31, 2016 was not available when the 2016-17 budget was prepared.

APPENDIX: ALBERTA HEALTH SERVICES' RESPONSIBILITIES UNDER THE REGIONAL HEALTH AUTHORITIES ACT

Consistent with the *Regional Health Authorities Act*, the 2016-17 AHS Health Plan and Business Plan outlines how the organization intends to fulfill its mandate over the next year.

AHS RESPONSIBILITIES	AHS OBJECTIVES
Promote and protect the health of the population of Alberta and work toward the prevention of disease and injury.	• Promote and support wellness for our communities.
Assess, on an ongoing basis, the health needs of Albertans.	• Optimize service delivery through needs-based service planning.
Determine priorities in the provision of health services in Alberta and allocate resources accordingly.	• Ensure investment in new technology and/or information management systems supports care delivery (IM/IT Strategy). • Integrate research, innovation and analytics in the delivery of care (Strategy for Clinical Health Research, Innovation and Analytics).
Ensure reasonable access to quality health services is provided in and through AHS.	• Enhance community-based options. • Improve system flow. • Improve surgical capacity management. • Improve co-ordination of emergency medical services in rural and remote communities. • Ensure a quality and safety focus in patient care (Patient First Strategy).
Promote the provision of health services in a manner that is responsive to the needs of individuals and communities and supports the integration of services and facilities in Alberta.	• Provide better transitions in care (Patient First Strategy). • Improve the patient experience (Patient First Strategy). • Engage staff, physicians and volunteers in a culture of patient- and family-centred care (Our People Strategy).

For more information about our programs and services, please visit
www.ahs.ca
or call HEALTHLink at 811.

2016-17

Alberta Health Services

Health Plan & Business Plan

Alberta Health Services